# MEDICAL AND/OR OTHER EXPENSES FORM

This form is to be completed when you are seeking reimbursement of medical and/or other expenses.

Please ensure you complete this form and attach a copy of clearly marked receipts on A4 paper for prompt reimbursement. If the space provided below is insufficient, please attach a separate sheet.

## Injured worker details

CLAIM NUMBER

SURNAME

GIVEN NAME

ADDRESS

POSTCODE

| DATE OF SERVICE | SERVICE PROVIDER NAME | SERVICE PROVIDED | AMOUNT |
|---|---|---|---|
| | | | $ |
| | | | $ |
| | | | $ |
| | | | $ |
| | | | $ |
| | | | $ |
| | | | $ |
| | | | $ |
| | | | $ |
| | | | $ |
| | | | $ |
| | | | $ |
| | | | $ |
| | | | $ |

***Receipts must be attached**

**TOTAL**

You can scan and attach your correspondence to an email and send to: **workerscompclaims@iag.com.au**

Please ensure our claim number is included in the subject line of your email.

Alternatively, you can use free postage within Australia (no stamp required) by addressing your envelope to:

WFI Workers Compensation Claims
Reply Paid 85245
Welshpool DC WA 6986

SIGNATURE

DATE D D / M M / Y Y

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